

**Child Deaths in Davidson County,
Tennessee
2001**



**Eighth Annual Report
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Child Deaths in Davidson County, Tennessee, 2001

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Executive Summary

The Child Death Review Team (CDRT) in Davidson County is a multi-disciplinary group that works to understand the causes of death of resident children under the age of 18 years. Founded in 1994 by a Mayoral Executive Order, the team is directed to affect system and policy change, thereby preventing future deaths. Members of the team represent a variety of disciplines including public health, law enforcement, medicine, and social service.

In Davidson County during the year 2001, 110 resident children died. The CDRT determined the manner of death to be natural causes for 71.8% (79 deaths) of the cases, and unintentional injuries for 16.4% (18 deaths). Homicide accounted for 7.3% (8 deaths) of the cases reviewed, and suicide accounted for 1.8% (2 deaths). The manner of death could not be determined for 2.7% (3 deaths) of the cases reviewed.

The largest group of child deaths occurred among children less than one year of age (68%). Of these, nearly 89% (75 deaths) died of natural causes and 30.7% (23 deaths) survived less than one day after birth. The next largest group of child deaths occurred among children aged 13 – 17 years (13.6%). Of these, nearly one-third died from unintentional injuries.

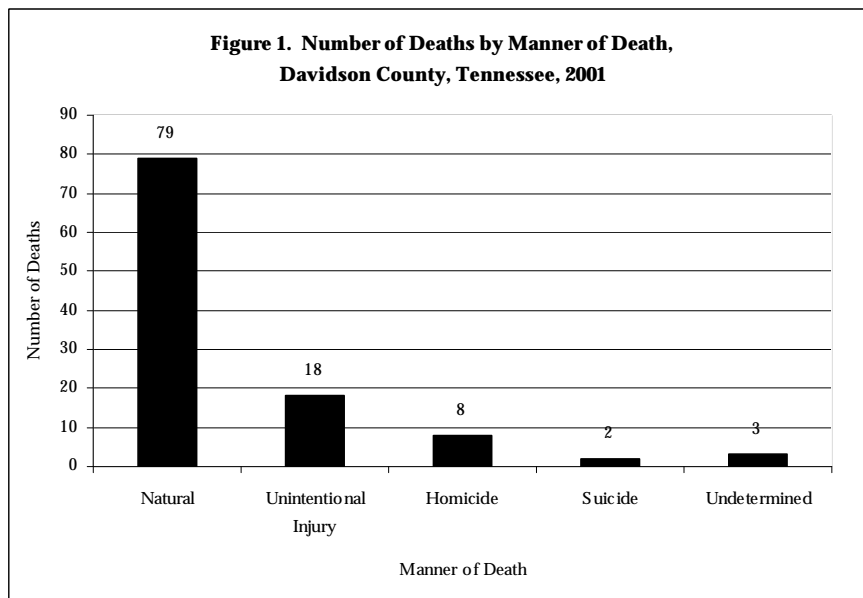
Each year, the CDRT makes recommendations for policy and service changes based on the results from child death investigations in an effort to prevent future childhood mortality. For the year 2001, the CDRT suggests that service delivery can be improved by providing counseling referrals to families impacted by suicide and by ensuring that no child is released from state custody into a home without first conducting an intensive home safety study. The CDRT also recommends that criminal background checks be conducted on the last individual in contact with an infant whose death is unexplained. Lastly, the CDRT strongly suggests changes be made to the Organ Donor Law that will allow the Medical Examiner to approve organ donation in cases of child death.

Overview of Child Deaths in Davidson County for 2001

There were a total of 110 fatalities recorded among resident children under the age of 18 in 2001 for Davidson County. The Child Death Review Team (CDRT) conducted a mutli-disciplinary team review of all 110 deaths. This report presents the findings and recommendations of the team.

The CDRT judged 20% of the birth certificates and 39% of the death certificates to be incomplete or inaccurate. Errors and incomplete information in vital statistics data has the potential of hindering the efforts of the CDRT. The types of errors found on birth certificates, for example, include inaccurate prenatal care information, incomplete recording of maternal medical risk factors, and incorrect recording of abnormalities of the child at birth. Death certificate errors tend to be primarily errors of omission. The fields most commonly left blank are manner of death and whether or not an autopsy was performed. Despite incomplete information, however, the CDRT agreed with the manner of death indicated on the death certificate in 77.3% of the cases. The manner of death was not indicated on the death certificate for 15.4% of the cases. In those instances, the manner of death was determined by the CDRT.

The CDRT determined the manner of death to be natural causes for 71.8% of the cases and unintentional injuries for 16.4%. Homicide accounted for 7.3% of the cases reviewed, and suicide accounted for 1.8%. The manner of death could not be determined for 2.7% of the cases reviewed. (See Figure 1.)



The largest group of child deaths occurred among children less than one year old (68%). Of these, nearly 89% died of natural causes and 30.7% survived less than 24 hours after birth. The next largest group of child deaths occurred among children aged 13 – 17 (13.6%). Of these, nearly one-third died from unintentional injuries. (See Table 1 on page 4.)

Demographically, 60.9% of child deaths in Davidson County during 2001 were male. Furthermore, more males than females died in each manner of death category. The number of male deaths due to natural causes, for example, is 32.3% higher than the number of female deaths. (See Figure 2 on page 4.)

Nearly 45% of child deaths were reported as white, 48.2% were reported as black, and 7.3% were reported as other races. Only 6.4% of child deaths were recorded as Hispanic. (Data not shown.) The distribution of deaths across manner of death, however, is not as consistent as the pattern noted for sex. For example, the number of black deaths due to natural causes is 14.7% higher than the number of white deaths; however, the number of white deaths due to unintentional injury is approximately twice as high as the number of black deaths. (See Figure 3.)

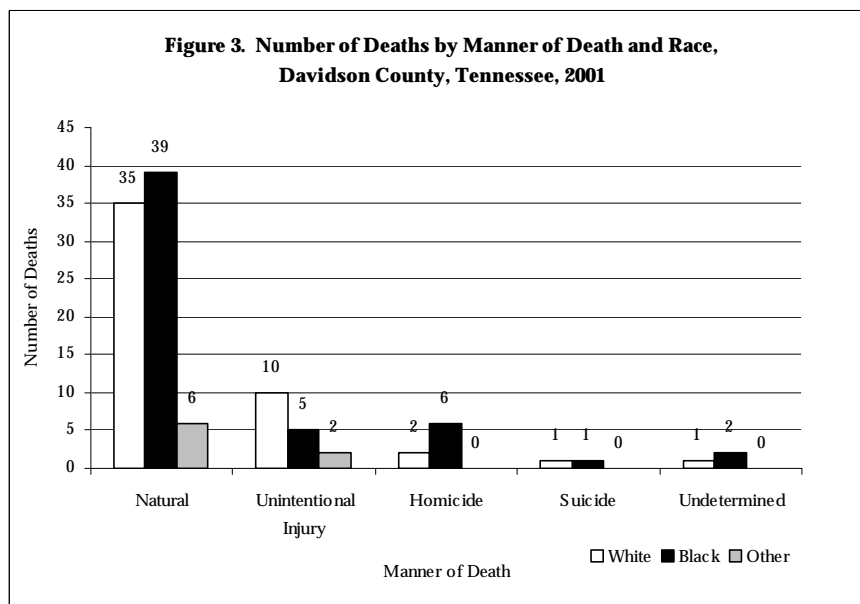


Table 2 depicts the number and percentage of child deaths by manner of death and maternal age at birth. In 2001, nearly half of all deaths occurred to children born to mothers between the ages of 20 and 29. Of these, 76% were due to natural causes. Nearly 25% of all deaths occurred in children born to mothers between the ages of 30 and 39. Of the deaths in this age category, nearly 78% were due to natural causes. The remaining deaths occurred to children born to mothers aged 40 years and greater (12.7%) or less than 20 years (17.2%).

The CDRT evaluates the presence of a history with child protective services, the presence of abuse and neglect, and the presence of a delay in seeking medical treatment with each child death. In some cases, there is enough evidence to raise suspicion, but not enough evidence to provide a

Table 1. Number and Percentage of Deaths by Manner of Death and Age, Race, and Sex, Davidson County, Tennessee, 2001

Manner of Death	Total		Age							Sex		Race		
	N	%	Detail of Cases < 1 year			All Cases				Male	Female	White	Black	Other
			<1 day	1-28 days	29-364 days	< 1 year	1-5 years	6-12 years	13-17 years					
Natural	79	71.8	22	23	22	67	2	6	4	45	34	34	39	6
Unintentional Injury	18	16.4	0	1	2	3	7	3	5	10	8	11	5	2
Homicide	8	7.3	0	0	2	2	2	0	4	7	1	2	6	0
Suicide	2	1.8	0	0	0	0	0	0	2	2	0	1	1	0
Undetermined	3	2.7	1	1	1	3	0	0	0	3	0	1	2	0
Total	110	100	23	25	27	75	11	9	15	67	43	49	53	8
Percentage*	100		30.7	33.3	36	68.2	10	8.2	13.6	60.9	39.1	44.6	48.2	7.3

*Percentage of total deaths

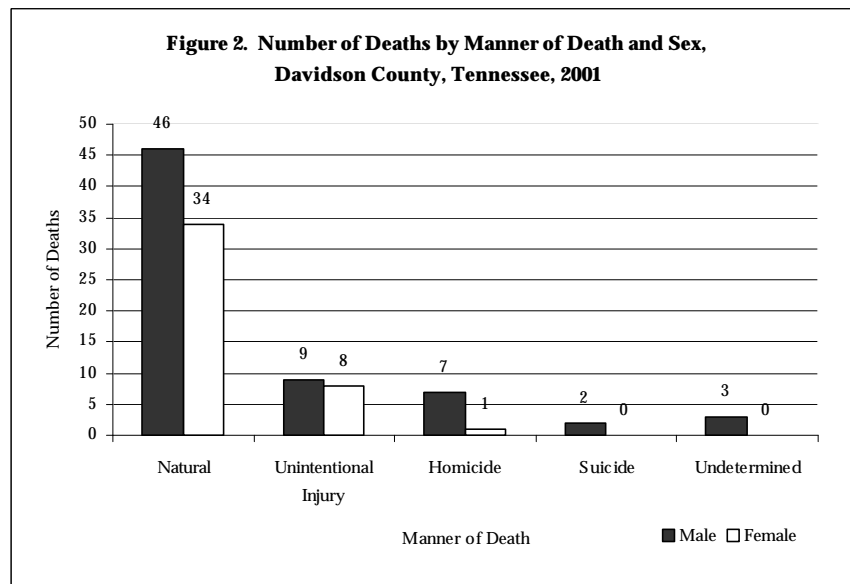


Table 2. Number and Percentage of Deaths by Manner of Death and Maternal Age, Davidson County, Tennessee, 2001

Manner of Death	Total		Maternal Age					
	N	%	13-14	15-17	18-19	20-29	30-39	40+
Natural	79	71.8	0	4	9	38	21	7
Unintentional Injury	18	16.4	0	2	1	7	4	4
Homicide	8	7.3	0	2	1	4	0	1
Suicide	2	1.8	0	0	0	0	1	1
Undetermined	3	2.7	0	0	0	1	1	1
Total	110	100	0	8	11	50	27	14
Percentage*	100		0	7.2	10	45.5	24.6	12.7

*Percentage of total deaths

definitive answer. In those situations, the CDRT marks the case as unknown. In 2001, 18.2% (20 deaths) of cases had prior involvement with child protective services (1 case unknown). The CDRT suspected child abuse and neglect in 7.3% (8 cases, 8 unknown) of the child death cases. Among suspected abuse and neglect cases, 75% (6 cases) also had child protective services involvement. Among the 8 unknown abuse and neglect cases, only 2 (25%) were reported as also having child protective services involvement. Less than 1% (1 case) of cases demonstrated evidence of a delay in seeking medical treatment for the child (12 unknown).

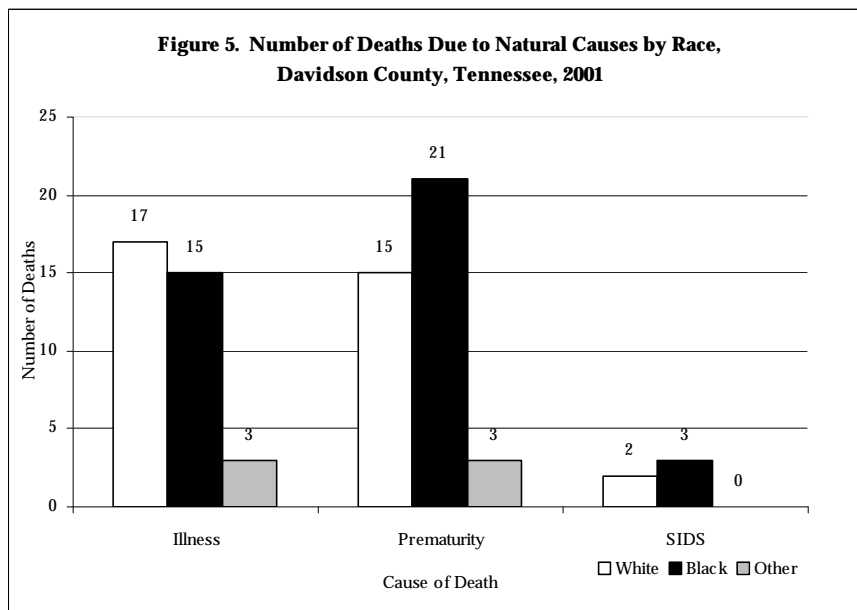
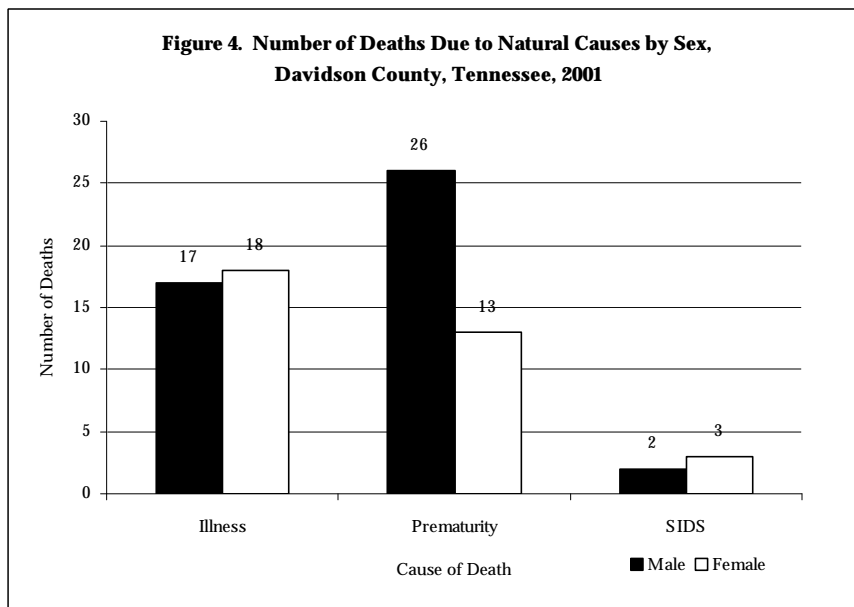
Deaths Due to Natural Causes

In Davidson County during 2001, there were 79 child deaths due to natural causes. These 79 deaths represent 71.8% of all child deaths. Of these deaths due to natural causes, 44.3% resulted from illness or other natural cause, 49.4% resulted from prematurity, and 6.3% were due to Sudden Infant Death Syndrome (SIDS). (See Table 3 on page 8.)

The majority of deaths due to natural causes involved infants, with 84.8% occurring among children less than one year of age. Examining infant deaths due to natural causes reveals that 27.8% involved newborns less than one day old, 29.1% involved infants less than one month old, and 27.8% involved infants less than one year old. Beyond one year of age, the age group with the greatest number of deaths was children 6-12 years of age (7.6%).

There were more male deaths due to natural causes (57%) than females (43%). Prematurity was the only cause of death in which male deaths greatly outnumbered females. The number of male deaths due to prematurity was twice as high as the number for females. (See Figure 4.)

Demographically, 43% of natural deaths were reported as white, 49.4% were reported as black, and 7.6% were reported as other races. The number of black deaths due to illness or other natural causes is 11.8% lower than the number of white deaths. However, the number of black deaths due to prematurity is 40% higher than the number of white deaths due to the same cause. (See Figure 5.)



Deaths Due to Natural Causes: Illness or Other Natural Cause

Thirty-five children died from illnesses or other conditions in Davidson County during the year 2001. These 35 deaths represent 44.3% of all deaths due to natural causes and nearly 32% of all child deaths for the year. The majority (65.7%) of all deaths due to illnesses involved children less than 1 year of age. These deaths are nearly equally divided between males (48.6%) and females (51.4%), but the number of black deaths is 11.8% lower than the number of white deaths. (See Table 3 on page 8.)

The leading cause of death among deaths due to illnesses and other natural causes is congenital anomalies, accounting for 15 (42.9%). The second leading cause is cancer, accounting for 7 (20%) deaths. The category labeled as other contains deaths where the cause is undetermined and deaths that do not fit into any other category. As such, it is a remainder grouping and does not count as a true cause of death. (See Figure 6.)

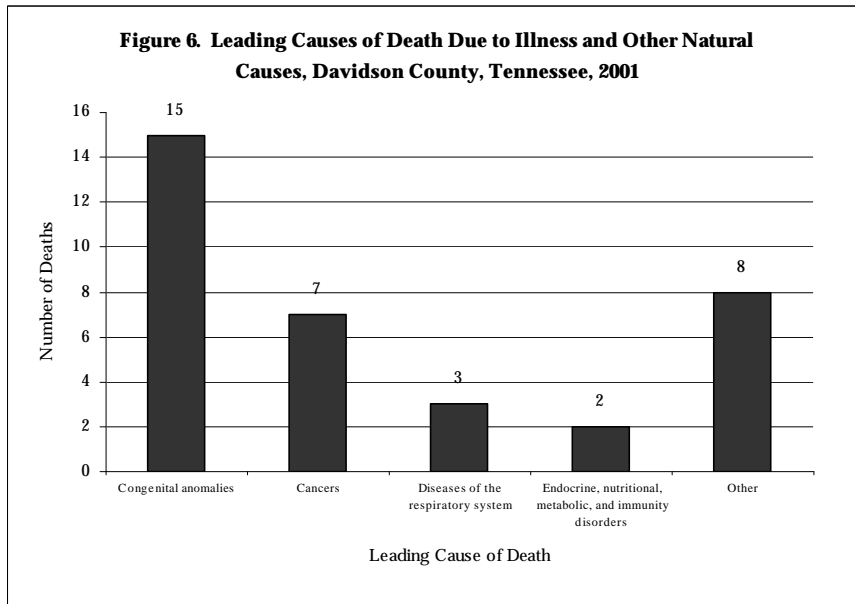


Table 3. Number and Percentage of Deaths Due to Natural Causes by Age, Sex, and Race, Davidson County, Tennessee, 2001

Cause of Death	Total		Age							Sex		Race		
	N	%	Detail of Cases < 1 year			All Cases				Male	Female	White	Black	Other
			<1 day	1-28 days	29-364 days	< 1 year	1-5 years	6-12 years	13-17 years					
Illness or Other Natural Cause	35	44.3	0	8	15	23	2	6	4	17	18	17	15	3
Prematurity	39	49.4	22	14	3	39	0	0	0	26	13	15	21	3
SIDS	5	6.3	0	1	4	5	0	0	0	2	3	2	3	0
Total	79	100	22	23	22	67	2	6	4	45	34	34	39	6
Percentage*	100		27.8	29.1	27.8	84.8	2.5	7.6	5.1	57	43	43	49.4	7.6

*Percentage of total deaths

Table 4. Number and Percentage of Deaths Due to Prematurity by Gestational Age, Age at Death, Birth Weight, Sex, and Race, Davidson County, Tennessee, 2001

Gestational Age	Total		Age			Birth weight in grams				Sex		Race		
	N	%	<1 day	1-28 days	29-364 days	< 500	500-1499	1500-2499	2500+	Male	Female	White	Black	Other
22 weeks or less	10	26.3	10	0	0	9	1	0	0	6	4	3	7	0
23 - 27 weeks	28	73.7	11	14	3	5	18	2	3	20	8	12	13	3
Total ¹	38	100	21	14	3	14	19	2	3	26	12	15	20	3
Percentage ²	100		55.3	36.8	7.9	36.8	50	5.3	7.9	68.4	31.6	39.5	52.6	7.9

¹Gestational age was not reported on one death. This death was excluded from this part of the analysis.

²Percentage of total deaths

Deaths Due to Natural Causes: Prematurity

Thirty-nine infants died from complications due to prematurity in Davidson County during the year 2001. These 39 deaths represent 49.4% of all deaths due to natural causes and 35.5% of all deaths to children in 2001.

Examining prematurity deaths by gestational age reveals that 10 deaths (26.3%) were 22 weeks or less gestational age, 28 (73.7%) were between 23 and 37 weeks gestational age, and the gestational age was not reported for one case. Among the deaths due to prematurity born at 22 weeks or less, 100% died within 24 hours of birth. Additionally, 9 (90%) premature births weighed less than 500 grams, and 1 (10%) premature birth weighed between 500 and 1,499 grams.

Among the deaths due to prematurity born at 23 to 37 weeks gestational age, 11 (39.3%) died within 24 hours of birth, 14 (50%) died within the first 28 days of life, and 3 (10.7%) died between 29 and 364 days of life. Additionally, 5 (17.9%) premature births weighed less than 500 grams, 18 (64.3%) weighed between 500 and 1,499 grams, 2 (7.1%) weighed between 1,500 and 2,499 grams, and 3 (10.7%) weighed 2,500 grams or more. (See Table 4 on page 8.)

There are disparities in deaths due to prematurity for both sex and race. The number of prematurity deaths for males is over twice as high as the number of deaths for females. Similarly, the number of deaths for blacks is 33% higher than the number of deaths for whites.

Deaths Due to Natural Causes: SIDS

Five children died as a result of SIDS in Davidson County during the year 2001. These 5 deaths represent 6.3% of all deaths due to natural causes and 4.5% of all child deaths.

Sleeping position was not reported for 3 of the 5 deaths. Among those whose sleeping position was reported, one was on its back, and one was face down on its stomach. Similarly, the presence of smoking in the house was not reported for 3 of the 5 deaths. However, both deaths for which information is available reported having smokers in the household.

Deaths Due to Unintentional Injury

Eighteen children died due to unintentional injuries in Davidson County during 2001. These 18 deaths represent 16.4% of all childhood deaths. The majority of these deaths resulted from vehicular incidents (61%). The next most common causes of unintentional injury deaths are fire-related and drownings (11%). (See Table 5 on page 10.)

Demographically, the greatest number of deaths due to unintentional injury occurred among children aged 1 to 5 years (7). The next highest number of deaths occurred among children aged 13 to 17 years (5). Deaths among males and females are nearly equivalent with males comprising only slightly greater than half the total deaths due to unintentional injury (55.6%). Whites comprise the majority of injury related deaths (61.1%), with blacks comprising the second highest group of fatalities (27.8%). (See Table 5.)

Table 5. Number and Percentage of Deaths Due to Unintentional Injury by Age, Sex, and Race, Davidson County, Tennessee, 2001

Cause of Death	Total		Age				Sex		Race		
	N	%	< 1 year	1-5 years	6-12 years	13-17 years	Male	Female	White	Black	Other
Vehicular	11	61.1	2	3	1	5	6	5	5	4	2
Firearm	1	5.6	0	0	1	0	1	0	0	1	0
Drowning	2	11.1	0	2	0	0	1	1	2	0	0
Suffocation	1	5.6	1	0	0	0	0	1	1	0	0
Fire/Burn	2	11.1	0	1	1	0	1	1	2	0	0
Poisoning	1	5.6	0	1	0	0	1	0	1	0	0
Total	18	100	3	7	3	5	10	8	11	5	2
Percentage*	100		16.7	38.9	16.7	27.8	55.6	44.4	61.1	27.8	11.1

*Percentage of total deaths

Deaths Due to Unintentional Injury: Motor Vehicle Crashes

Eleven children died in motor vehicle crashes in Davidson County during the year 2001. These 11 deaths represent 61% of all deaths due to unintentional injuries and 10% of all child deaths. The numbers of deaths for males and females and whites and blacks are roughly equivalent. Nearly 55% of all vehicular deaths are male and approximately 45% are female. Whites represent approximately 45% of all vehicular deaths, blacks represent approximately 36% of those deaths, and children reported as other races comprise the remaining 18%. (See Table 5 on page 10.)

With regards to age, 45.5% of vehicular deaths occurred to children aged 13 to 17 years. The next highest number of deaths occurred to children aged 1 to 5 years (27.2%), followed by infants less than one year of age (18.2%), and children aged 6 to 12 years (9.0%).

One incident involved an unborn fetus; however, the details of the motor vehicle crash are unknown. For the remaining deaths, the fatally injured child was the driver in 3 of the incidents, the passenger in 5 of the incidents, and a pedestrian in 2 incidents. Regarding safety belt usage, 3 incidents report a safety belt in the vehicle, but not being used, and 3 report proper safety belt usage. The details regarding safety belt usage are unknown for 3 incidents and not applicable for the 2 pedestrian deaths. Information regarding child safety seat usage is available for 4 deaths of which 2 report not having a child safety seat in the vehicle and 2 report incorrect seat usage.

Examining the circumstances surrounding the motor vehicle crashes reveals that speed was indicated in 3 cases, a mechanical failure was indicated in 1 case, and other factors were indicated in 2 deaths. Regarding the two deaths that involved other factors, 1 resulted from the driver falling asleep, and the other resulted from the driver losing control of the car. Information regarding road conditions is not applicable to the situation in one death and is unknown in 2 deaths. However, normal road conditions were reported most frequently (6), and wet conditions were only recorded in 2 deaths.

Deaths Due to Unintentional Injury: Firearms, Drowning, Suffocation, Fire and Burns, Poisoning

During 2001, there was 1 unintentional death due to a firearm, 2 deaths due to drowning, 1 death due to suffocation, 2 deaths due to fire and burns, and 1 death due to poisoning. Together these 7 deaths represent nearly 40% of all deaths due to unintentional injuries and 7.3% of all child deaths in 2001. (See Table 5.)

The firearm death involved a child playing with a handgun that was found in an unlocked drawer. Both drownings occurred in swimming pools. Utilization of flotation devices is unknown in 1 case. In the other case, the child was not wearing a flotation device. Overlying, or one individual rolling over or lying on top of the child, was the cause of the 1 unintentional death due to suffocation. This child was placed on a soft-sleeping surface. Both deaths due to fire resulted from lit cigarettes, and both children died from smoke inhalation. It is unknown if either location had an operational smoke detector present. The last death was due to an unintentional poisoning with a family member's prescription.

Deaths Due to Violence: Homicide and Suicide

Violence-related deaths are those determined to be either suicides or homicides. There was a total of 10 violence-related deaths in Davidson County during the year 2001 - 8 (80%) homicides and 2 (20%) suicides. Together, violence-related deaths comprise 9.0% of all childhood deaths. Of these deaths, 90% were male and 10% were female. Blacks comprised 70% of violence-related deaths, and whites comprised 30%. There were no violent deaths reported for other races.

Among homicides, 2 were due to suspected arson, 3 were due to firearms, 2 were due to other inflicted injuries, and 1 was due to suffocation. The circumstances surrounding 1 firearm death are unknown; however, the 2 remaining deaths both involved the use of handguns. Both injury deaths were due to the use of hands and/or feet to inflict injury. Among suicides, 1 death utilized a firearm, and 1 death utilized a vehicle.

Child Death Review Team Accomplishments for 2001

- ◆ Based in large part on a recommendation from the Nashville Child Death Review Team, the State of Tennessee agreed to include “Back to Sleep” posters and information in all day care center audits.
- ◆ The Metro Public Health Department (MPHD) Child and Adolescent Health Division and the Medical Examiner’s Office developed a method of sharing SIDS information to allow MPHD staff to provide adequate, timely follow-up to impacted families.
- ◆ During 2001, 110 cases were reviewed.

Child Death Review Team Recommendations for 2001

1. The Organ Donor Law should be revised. Currently, the next of kin may give permission to donate organs, even in cases where there is suspicion that the next of kin may be the person who fatally injured the child. Children on life support are particularly vulnerable as the current Medical Examiner Law is suspended in these cases. In cases of pediatric homicide, the parent/killer may gladly give permission to donate organs, thus permanently erasing important evidence and thereby escaping conviction. This problem is further fueled by the aggressive efforts of organ procurement organizations. In most states the Medical Examiner has the right to approve organ donations. This is not the case in Tennessee.
2. Police officers should refer families impacted by suicide to Family and Children Services or a similar organization for counseling.
3. Juvenile Court should not release children into any home before a full home safety study is completed.
4. A criminal background check and a Department of Children’s Services (DCS) file check should be run on the last person who was in contact with the infant on all unexplained infant deaths. DCS can release this information to the Medical Examiner.

Appendix

The Child Fatality Review Process

When a child dies:

1. The birth and death certificate is sent from the Metropolitan Public Health Department (MPHD) Vital Statistics staff to the Child Death Review Team data coordinator.
2. Copies of the birth and death records are sent to the Team members. Available records are requested from programs within the MPHD (HUG, Healthy Start, WIC, etc.).
3. All team members search their agency/hospital files and bring either the records or case summaries to team meetings.
4. The team meets once a month. At these meetings, each case is reviewed and the paperwork is completed.
5. The data coordinator enters the data into a database and sends the completed data forms to the State Fatality Review Program.
6. An annual report is produced. The purpose of the report is to disseminate findings and assist in the development of data-driven recommendations for the prevention of child deaths.

Child Death Review Team Data Collection Form, Side 1

This information is confidential

**TENNESSEE DEPARTMENT OF HEALTH
CHILD FATALITY REVIEW TEAM
REVIEW/DATA COLLECTION**

MCH 1/01

Judicial District No.: _____		Child Death Year/No.: <u>2002</u> / <u>1</u> / <u>1</u>	
Child's Name: _____			
Date of Death: ____/____/____		Date of Birth: ____/____/____	
Address: _____		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
City: _____		Zip Code: _____	
Race: <input type="checkbox"/> White <input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> Other: _____			
Ethnicity: Hispanic origin? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Mother's Name: _____			
Mother's Date of Birth: ____/____/____		Maiden: _____	
Census Tract: _____		County of Residence: _____	
Birth Weight: ____ kg / ____ gm / ____ lb / ____ oz		Clinical Estimate of Gestation (weeks): _____	
Abnormal Conditions: _____		Congenital Anomalies: _____	
Prenatal Care Questions:			
Specify Month Prenatal Care Began: _____		<input type="checkbox"/> No Prenatal Care <input type="checkbox"/> Unknown	
Number of Prenatal Visits: _____		<input type="checkbox"/> No Visits <input type="checkbox"/> Unknown	
Risk Factors: Tobacco Use: <input type="checkbox"/> Yes <input type="checkbox"/> No No. of cigarettes per day: _____			
Alcohol Use: <input type="checkbox"/> Yes <input type="checkbox"/> No No. of drinks per week: _____			
Chemical Substance Abuse: <input type="checkbox"/> Yes <input type="checkbox"/> No Specify: _____			
To the best of the team's knowledge, is the Birth Certificate information correct/complete? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Death Certificate Number: _____		Is the Death Certificate adequate/complete? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Manner of death on Death Certificate: <input type="checkbox"/> Homicide <input type="checkbox"/> Suicide <input type="checkbox"/> Accidental <input type="checkbox"/> Natural			
<input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined <input type="checkbox"/> Blank			
Place of Death: <input type="checkbox"/> Hospital Inpatient <input type="checkbox"/> At Scene of Incident			
<input type="checkbox"/> Hospital Emergency Room <input type="checkbox"/> Child's Residence			
<input type="checkbox"/> In Transit <input type="checkbox"/> Relative's/Friend's Home			
<input type="checkbox"/> Institutional Setting <input type="checkbox"/> Child Care			
Was an autopsy performed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
If Yes, location: <input type="checkbox"/> Medical Examiner <input type="checkbox"/> Hospital <input type="checkbox"/> Other: _____			
Review team comments/recommendations and prevention issues (for local team use): _____ _____ _____		Recommended for additional review? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Which reports/records were requested for full review? <input type="checkbox"/> Law enforcement <input type="checkbox"/> Court <input type="checkbox"/> DA report <input type="checkbox"/> School <input type="checkbox"/> DHS <input type="checkbox"/> Health Dept. <input type="checkbox"/> Med. Exam autopsy <input type="checkbox"/> Hospital autopsy <input type="checkbox"/> Attending physician <input type="checkbox"/> Other: _____	
1 st Review: ____/____/____		2 nd Review: ____/____/____	
3 rd Review: ____/____/____		Date case closed by CFRT: ____/____/____	

PH-3668

RDA-pending

Child Death Review Team Data Collection Form, Side 2

<p><input type="checkbox"/> 1. Sudden Infant Death Syndrome (SIDS)</p> <p>A. Position of infant on discovery?</p> <p>1. <input type="checkbox"/> On stomach, face down 2. <input type="checkbox"/> On stomach, face to side 3. <input type="checkbox"/> On back 4. <input type="checkbox"/> On side 5. <input type="checkbox"/> Unknown</p> <p>B. Sleeping with another person? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>C. Smoker in household? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p><input type="checkbox"/> 2. Lack of Adequate Care</p> <p>A. Apparent lack of supervision? <input type="checkbox"/> Yes <input type="checkbox"/> No B. Apparent lack of medical care? <input type="checkbox"/> Yes <input type="checkbox"/> No C. If yes: 1. <input type="checkbox"/> Malnutrition or dehydration 2. <input type="checkbox"/> Oral water intoxication 3. <input type="checkbox"/> Delayed medical care 4. <input type="checkbox"/> Inadequate medical attention 5. <input type="checkbox"/> Out-of-hospital birth 6. <input type="checkbox"/> Other: _____ 7. <input type="checkbox"/> Unknown</p> <p><input type="checkbox"/> 3. Prematurity (less than 37 weeks gestation)</p> <p>A. <input type="checkbox"/> Known Condition _____</p> <p><input type="checkbox"/> 4. Illness or Other Natural Cause</p> <p>A. <input type="checkbox"/> Known condition _____ B. <input type="checkbox"/> Unknown</p> <p><input type="checkbox"/> 5. Drowning</p> <p>A. Place of drowning?</p> <p>1. <input type="checkbox"/> Creek, river, pond or lake Location prior to drowning? a. <input type="checkbox"/> Boat b. <input type="checkbox"/> Waters edge c. <input type="checkbox"/> Other _____ d. <input type="checkbox"/> Unknown</p> <p>2. <input type="checkbox"/> Well, cistern, or septic tank 3. <input type="checkbox"/> Bathtub 4. <input type="checkbox"/> Swimming pool 5. <input type="checkbox"/> Bucket 6. <input type="checkbox"/> Wading pool 7. <input type="checkbox"/> Other: _____ 8. <input type="checkbox"/> Unknown</p> <p>B. Wearing flotation device? 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 3. <input type="checkbox"/> Unknown 4. <input type="checkbox"/> NA</p> <p>C. <input type="checkbox"/> Circumstances Unknown</p> <p><input type="checkbox"/> 6. Suffocation/Strangulation</p> <p>A. Circumstances of the event?</p> <p>1. <input type="checkbox"/> Other person overlying or rolling over decedent? 2. <input type="checkbox"/> Caused by other person, not overlying or rolling over 3. <input type="checkbox"/> Self-inflicted by decedent 4. <input type="checkbox"/> Not inflicted by any person 5. <input type="checkbox"/> Other: _____ 6. <input type="checkbox"/> Unknown</p> <p>B. Object impeding breath?</p> <p>1. <input type="checkbox"/> Food 2. <input type="checkbox"/> Other person's hand(s) 3. <input type="checkbox"/> Small object or toy in mouth 4. <input type="checkbox"/> Object (e.g., plastic bag) covering victim's mouth/nose 5. <input type="checkbox"/> Object (e.g., rope) exerting pressure on victim's neck 6. <input type="checkbox"/> Other: _____ 7. <input type="checkbox"/> Unknown</p> <p>C. Injury occurred in bed, crib, or other sleeping arrangement? 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 3. <input type="checkbox"/> Unknown</p> <p>D. If in bed/crib, due to:</p> <p>1. <input type="checkbox"/> Hazardous design of crib/bed 2. <input type="checkbox"/> Malfunction/improper use of crib/bed 3. <input type="checkbox"/> Placement on soft sleeping surface (e.g., waterbed) 4. <input type="checkbox"/> Other: _____ 5. <input type="checkbox"/> Unknown 6. <input type="checkbox"/> NA</p> <p>E. Due to carbon monoxide inhalation? 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 3. <input type="checkbox"/> Unknown</p> <p>F. <input type="checkbox"/> Circumstances unknown</p>	<p><input type="checkbox"/> 7. Vehicular</p> <p>A. # and type of vehicles involved:</p> <p>1. <input type="checkbox"/> Cars 2. <input type="checkbox"/> All-terrain vehicles 3. <input type="checkbox"/> Motorcycles 4. <input type="checkbox"/> Riding mowers 5. <input type="checkbox"/> Bicycles 6. <input type="checkbox"/> Farm tractors 7. <input type="checkbox"/> Other farm vehicles 8. <input type="checkbox"/> Truck/RV 9. <input type="checkbox"/> Other _____ 10. <input type="checkbox"/> Unknown</p> <p>B. Position of decedent?</p> <p>1. <input type="checkbox"/> Driver 2. <input type="checkbox"/> Pedestrian 3. <input type="checkbox"/> Passenger 4. <input type="checkbox"/> Back of truck 5. <input type="checkbox"/> Other: _____ 6. <input type="checkbox"/> Unknown</p> <p>C. Type vehicle in which decedent was occupant?</p> <p>1. <input type="checkbox"/> Car 2. <input type="checkbox"/> All-terrain vehicle 3. <input type="checkbox"/> Motorcycle 4. <input type="checkbox"/> Riding mower 5. <input type="checkbox"/> Bicycle 6. <input type="checkbox"/> Farm tractor 7. <input type="checkbox"/> Other farm vehicle 8. <input type="checkbox"/> Truck/RV 9. <input type="checkbox"/> Other: _____ 10. <input type="checkbox"/> Unknown</p> <p>D. Decedent's safety belt use?</p> <p>1. <input type="checkbox"/> Present in vehicle, but not used 2. <input type="checkbox"/> None in vehicle 3. <input type="checkbox"/> Restraint used 4. <input type="checkbox"/> Unknown 5. <input type="checkbox"/> NA</p> <p>E. Decedent's infant/toddler seat use?</p> <p>1. <input type="checkbox"/> Present in vehicle, but not used 2. <input type="checkbox"/> None in vehicle 3. <input type="checkbox"/> Seat used correctly 4. <input type="checkbox"/> Seat used incorrectly 5. <input type="checkbox"/> NA</p> <p>F. Decedent was wearing a helmet? 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 3. <input type="checkbox"/> Unknown 4. <input type="checkbox"/> NA</p> <p>G. Vehicle in which decedent was occupant?</p> <p>1. <input type="checkbox"/> Age of driver _____ <input type="checkbox"/> Unknown 2. <input type="checkbox"/> Operator driving impaired (alcohol/drug) 3. <input type="checkbox"/> Speed/recklessness indicated 4. <input type="checkbox"/> Other violation by operator 5. <input type="checkbox"/> Mechanical failure 6. <input type="checkbox"/> Other: _____ 7. <input type="checkbox"/> Unknown 8. <input type="checkbox"/> NA</p> <p>H. Vehicle in which decedent was not occupant?</p> <p>1. <input type="checkbox"/> Age of driver _____ <input type="checkbox"/> Unknown 2. <input type="checkbox"/> Operator driving impaired (alcohol/drug) 3. <input type="checkbox"/> Speed/recklessness indicated 4. <input type="checkbox"/> Other violation by operator 5. <input type="checkbox"/> Mechanical failure 6. <input type="checkbox"/> Other: _____ 7. <input type="checkbox"/> Unknown 8. <input type="checkbox"/> NA</p> <p>I. Condition of road?</p> <p>1. <input type="checkbox"/> Normal 2. <input type="checkbox"/> Loose gravel 3. <input type="checkbox"/> Wet 4. <input type="checkbox"/> Ice or snow 5. <input type="checkbox"/> Other: _____ 6. <input type="checkbox"/> Unknown 7. <input type="checkbox"/> NA</p> <p>J. <input type="checkbox"/> Circumstances unknown</p> <p><input type="checkbox"/> 8. Firearm</p> <p>A. Person handling the firearm?</p> <p>1. <input type="checkbox"/> Decedent 2. <input type="checkbox"/> Parent 3. <input type="checkbox"/> Other: _____ 4. <input type="checkbox"/> Unknown</p> <p>B. Type firearm involved?</p> <p>1. <input type="checkbox"/> Handgun 2. <input type="checkbox"/> Rifle 3. <input type="checkbox"/> Shotgun 4. <input type="checkbox"/> Other: _____ 5. <input type="checkbox"/> Unknown</p> <p>C. Age of person handling firearm 1. <input type="checkbox"/> years 2. <input type="checkbox"/> Unknown</p> <p>D. Use of firearm at time of injury?</p> <p>1. <input type="checkbox"/> Shooting at other person 2. <input type="checkbox"/> Suicide 3. <input type="checkbox"/> Hunting 4. <input type="checkbox"/> Playing 5. <input type="checkbox"/> Other: _____ 6. <input type="checkbox"/> Unknown</p> <p>E. Was decedent's home source of firearm? 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 3. <input type="checkbox"/> Unknown</p> <p>F. <input type="checkbox"/> Circumstances unknown</p>	<p><input type="checkbox"/> 9. Inflicted Injury (NOT firearm or suffocation/strangulation)</p> <p>A. Who inflicted the injury?</p> <p>1. <input type="checkbox"/> Self-inflicted 2. <input type="checkbox"/> Parent 3. <input type="checkbox"/> Relative 4. <input type="checkbox"/> Other: _____</p> <p>B. Person inflicting injury?</p> <p>1. <input type="checkbox"/> Age _____ <input type="checkbox"/> Unknown 2. <input type="checkbox"/> Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female 3. <input type="checkbox"/> Race: <input type="checkbox"/> White <input type="checkbox"/> African American <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unknown</p> <p>C. Manner in which injury was inflicted?</p> <p>1. <input type="checkbox"/> Shaken 2. <input type="checkbox"/> Struck 3. <input type="checkbox"/> Thrown 4. <input type="checkbox"/> Cut/stabbed 5. <input type="checkbox"/> Sexual Assault 6. <input type="checkbox"/> Other: _____ 7. <input type="checkbox"/> Unknown</p> <p>D. Injury inflicted with?</p> <p>1. <input type="checkbox"/> Sharp object (e.g., knife, scissors) 2. <input type="checkbox"/> Blunt object (e.g., hammer, bat) 3. <input type="checkbox"/> Hot liquid or other substance 4. <input type="checkbox"/> Hand/foot 5. <input type="checkbox"/> Fire 6. <input type="checkbox"/> Other: _____ 7. <input type="checkbox"/> Unknown</p> <p>E. Where did injury occur?</p> <p>1. <input type="checkbox"/> Child's residence 2. <input type="checkbox"/> School 3. <input type="checkbox"/> Relative/friend's home 4. <input type="checkbox"/> Child care 5. <input type="checkbox"/> Other: _____ 6. <input type="checkbox"/> Unknown</p> <p>F. <input type="checkbox"/> Circumstances unknown</p> <p><input type="checkbox"/> 10. Poisoning/overdose</p> <p>A. Name of drug or chemical?</p> <p>1. <input type="checkbox"/> Name _____ 2. <input type="checkbox"/> Unknown</p> <p>B. <input type="checkbox"/> Circumstances unknown</p> <p><input type="checkbox"/> 11. Fire/burn</p> <p>A. If not a fire burn, its source?</p> <p>1. <input type="checkbox"/> Hot water, etc. 2. <input type="checkbox"/> Appliance 3. <input type="checkbox"/> Other: _____ 4. <input type="checkbox"/> Unknown 5. <input type="checkbox"/> NA</p> <p>B. If ignition/fire, what was source?</p> <p>1. <input type="checkbox"/> Oven/stove explosion 2. <input type="checkbox"/> Cooking appliance used as heat source 3. <input type="checkbox"/> Matches 4. <input type="checkbox"/> Lit cigarette 5. <input type="checkbox"/> Lighter 6. <input type="checkbox"/> Space heater 7. <input type="checkbox"/> Furnace 8. <input type="checkbox"/> Explosives 9. <input type="checkbox"/> Fireworks 10. <input type="checkbox"/> Electrical wiring 11. <input type="checkbox"/> Other: _____ 12. <input type="checkbox"/> Unknown 13. <input type="checkbox"/> NA</p> <p>C. Smoke alarm present at fire scene? 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 3. <input type="checkbox"/> Unknown</p> <p>D. If alarm present, did it sound? 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 3. <input type="checkbox"/> Unknown</p> <p>E. Was the fire started by a person? 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No 3. <input type="checkbox"/> Unknown</p> <p>F. If started by a person, his/her age: _____ years 1. <input type="checkbox"/> Unknown 2. <input type="checkbox"/> NA</p> <p>G. If started by a person, his/her activity</p> <p>1. <input type="checkbox"/> Playing 2. <input type="checkbox"/> Smoking 3. <input type="checkbox"/> Cooking 4. <input type="checkbox"/> Suspected arson 5. <input type="checkbox"/> Other: _____ 6. <input type="checkbox"/> Unknown 7. <input type="checkbox"/> NA</p> <p>H. Type of construction of building burned:</p> <p>1. <input type="checkbox"/> Wood frame 2. <input type="checkbox"/> Brick/stone 3. <input type="checkbox"/> Trailer 4. <input type="checkbox"/> Other: _____ 5. <input type="checkbox"/> Unknown 6. <input type="checkbox"/> NA</p> <p>I. Smoke inhalation death: 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No J. <input type="checkbox"/> Circumstances unknown</p> <p><input type="checkbox"/> 12. Other Cause Not Listed Above:</p> <p>_____</p> <p>_____</p> <p>_____</p>
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Executive Order Number 94-01

EXECUTIVE ORDER NO. 94-01

Subject: **Establishment of Child Death Review Team of the Metropolitan Government**

I, Philip Bredesen, Mayor of The Metropolitan Government of Nashville and Davidson County, by virtue of the power and authority vested in me, do hereby direct and order that:

1. A Child Death Review Team is hereby established for The Metropolitan Government of Nashville and Davidson County.
2. The Team shall have 10 members, consisting of the following:

Director of the Metropolitan Department of Health
Director of the Metropolitan Department of Social Services
Chief of the Department of Metropolitan Police
County Medical Examiner of Davidson County
Medical Director of "Our Kids, Inc."

The following elected officials are requested to serve as members of the Team or to designate representatives from their offices to do so:

District Attorney General of the 20th Judicial District of Tennessee
Judge of the Juvenile Court for Davidson County

In addition, the Commissioner of the Tennessee Department of Human Services is requested to designate a representative to serve on the team.

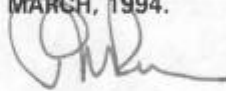
In addition to the foregoing, there shall be two other members, at least one of whom shall be a board certified pediatrician or a board certified child psychiatrist.
3. The purpose of the Team is to review the death of any child below 18 years of age legally residing in Davidson County at the time of death, irrespective of the location where the death occurred. In connection with its investigation, the Team shall assist in identifying information which could be pertinent in determining the manner of death in any unexpected child fatalities; identify preventable deaths and strategies for the prevention of future childhood fatalities, including any which might be related to limited access to health care; and collect statistical and other data and report annually to the Mayor relating how children are dying in Nashville and recommending appropriate strategies for prevention.
4. The Director of the Metropolitan Department of Health shall serve as the Chair of the Team.

Executive Order Number 94-01, continued

5. The Team shall meet monthly. Special meetings may be called at the discretion of the Chair; the District Attorney; or the Medical Examiner.
6. Members of the Team shall serve without compensation; however, travel and related expenses may be reimbursed pursuant to the Metropolitan Government's travel regulations, with the approval of the Director of Finance.
7. The Team shall observe confidentiality to the maximum extent permitted by law.
8. The Director of Law or a designee from the Department of Law shall serve as legal advisor to the Team.
9. Subject to the approval of the appropriate department head, the Team may utilize the services of any staff or resources of the Metropolitan Government. The Chair may include non-voting advisory members on an ad hoc basis to assist with specific cases or issues under review.

This order shall become effective on January 1, 1994.

ORDERED THIS 7th DAY OF
MARCH, 1994.



Philip Bredesen
Mayor

Child Fatality Review and Prevention Act of 1995

CHAPTER 142
CHILD FATALITY REVIEW AND
PREVENTION

Section

- 68-142-101. Short title.
- 68-142-102. Child fatality prevention team.
- 68-142-103. Composition.
- 68-142-104. Voting members-Vacancies
- 68-142-105. Duties of state team.
- 68-142-106. Local teams-Composition-Vacancy-Chair-Meetings
- 68-104-107. Duties of local teams.
- 68-104-108. Powers of local team-Limitations-Confidentiality of state and local team records.
- 68-104-109. Staff and consultants.

68-104-101. Short title.

The chapter shall be known as and may be cited as the "Child Fatality Review and Prevention Act of 1995."

[Acts 1995, ch.511, § 1.]

68-104-102. Child fatality prevention team.

There is hereby created the Tennessee child fatality prevention team, otherwise known as the state team. For administrative purposes only, the state team shall be attached to the department of health.

[Acts 1995, ch. 511, § 1.]

68-141-103. Composition.

The state team shall be composed as provided herein. Any ex officio member, other than the commissioner of health, may designate an agency representative to serve in such person's place.

Members of the state team shall be as follows:

- (1) The commissioner of health, who shall chair the state team;
- (2) The attorney general and reporter;
- (3) The commissioner of children's services;
- (4) The director of the Tennessee bureau of investigation;
- (5) A physician nominated by the state chapter of the American Medical Association;
- (6) A physician to be appointed by the commissioner of health who is credentialed in forensic pathology, preferably with experience in pediatric forensic pathology;
- (7) The commissioner of mental health and mental retardation;
- (8) A member of the judiciary selected from a list submitted by the chief justice of the Tennessee Supreme Court;
- (9) The executive director of the commission of children and youth;
- (10) The president of the state professional society on the abuse of children;

Child Fatality Review and Prevention Act of 1995, continued

- (11) A team coordinator, to be appointed by the commissioner of health;
- (12) The chair of the select committee on children and youth;

- (11) A team coordinator, to be appointed by the commissioner of health;
- (12) The chair of the select committee on children and youth;
- (13) Two (2) members of the house of representatives to be appointed by the speaker of the house, at least one (1) of whom shall be a member of the house health and human resources committee; and
- (14) Two (2) senators to be appointed by the speaker of the senate at least one (1) of whom shall be a member of the senate general welfare, health and human resources committee.

[Acts 1995, ch. 511, § 152.]

68-142-104. Voting members-Vacancies

All members of the state team shall be voting members. All vacancies shall be filled by the appointing or designating authority in accordance with the requirements of § 68-142-103.

[Acts 1995, ch. 511, § 1.]

68-142-105. Duties of state team.

The state team shall:

- (1) Review reports from the local child fatality review teams;
- (2) Report to the governor and the general assembly concerning the state team's activities and its recommendations for changes to any law, rule, and policy that would promote the safety and well-being of children;
- (3) Undertake annual statistical studies of the incidence and causes of child fatalities in this state. The studies shall include an analysis of community and public and private agency involvement with the decedents and their families prior to and subsequent to the deaths;
- (4) Provide training and written materials to the local teams established by this chapter to assist them in carrying out their duties. Such written materials may include model protocols for the operation of local teams;
- (5) Develop a protocol for the collection of data regarding child deaths;
- (6) Upon request of a local team, provide technical assistance to such team, including the authorization of another medical or legal opinion on a particular death; and
- (7) Periodically assess the operations of child fatality prevention efforts and make recommendations for changes as needed.

[Acts 1995, ch. 511, § 2.]

Child Fatality Review and Prevention Act of 1995, continued

68-142-106. Local teams-Composition-Vacancy-Chair-Meetings.

- (a) There shall be a minimum of one (1) local team in each judicial district;
- (b) Each local team shall include the following statutory members or their designees:
 - (1) A supervisor of social services in the department of children's services within the area served by the team;
 - (2) The regional health officer in the department of health in the area served by the team or such officer's designee, who shall serve as interim chair pending the election by the local team;
 - (3) A medical examiner who provides services in the area served by the team;
 - (4) A prosecuting attorney appointed by the district attorney general;
 - (5) The interim chair of the local team shall appoint the following members to the local team:
 - (A) A local law enforcement officer;
 - (B) A mental health professional;
 - (C) A pediatrician or family practice physician;
 - (D) An emergency medical service provider or firefighter; and
 - (E) A representative from a juvenile court.
- (c) Each local child fatality team may include representatives of public and nonpublic agencies in the community that provide services to children and their families;
- (d) The local team may include non-statutory members to assist them in carrying out their duties. Vacancies on a local team shall be filled by the original appointing authority;
- (e) A local team shall elect a member to serve as chair;
- (f) The chair of each local team shall schedule the time and place of the first meeting, and shall prepare the agenda. Thereafter, the team shall meet no less often than once per quarter and often enough to allow adequate review of the cases meeting the criteria for review.

[Acts 1995, ch. 511, § 3; 1996, ch. 1079, § 152.]

68-142-107. Duties of local teams.

- (a) The local child fatality review teams shall:
 - (1) Be established to cover each judicial district in the state;
 - (2) Review, in accordance with the procedures established by the state team, all deaths of children seventeen (17) years of age or younger;
 - (3) Collect data according to the protocol developed by the state team;
 - (4) Submit data on child deaths quarterly to the state team;
 - (5) Submit annually to the state team recommendations, if any, and advocate for system improvements and resources where gaps and deficiencies may exist; and
 - (6) Participate in training provided by the state team.
- (b) Nothing in this chapter shall preclude a local team from providing consultation to any team member conducting an investigation.
- (c) Local child fatality review teams may request a second medical or legal opinion to be authorized by the state team in the event that a majority of the local team's statutory membership is in agreement that a second opinion is needed.

[Acts 1995, ch. 511, § 4.]

Child Fatality Review and Prevention Act of 1995, continued

68-142-108. Posers of local team-Limitations-Confidentiality of state and local team records.

- (a) The local team shall have access to and subpoena power to obtain all medical records and records maintained by any state, county or local agency, including, but not limited to, police investigations data, medical examiner investigative data and social services records, as necessary to complete the review of a specific fatality.
- (b) The local team shall not, as part of the review authorized under this chapter, contact, question or interview the parent of the deceased child or any other family member of the child whose death is being reviewed.
- (c) The local team may request that persons with direct knowledge of circumstances surrounding a particular fatality provide the local team with information necessary to complete the review of the particular fatality, such persons may include the person or persons who first responded to a report concerning the child.
- (d) Meetings of the state team and each local team shall not be subject to the provisions of title 8, chapter 44, part 1. Any minutes or other information generated during official meetings of state or local teams shall be sealed from public inspection. However, the state and local teams may periodically make available, in a general manner not revealing confidential information about children and families, the aggregate findings of their reviews and their recommendations for preventive actions.
- (e) (1) All otherwise confidential information and records acquired by the state team or any local child fatality review team in the exercise of the duties are confidential, are not subject to discovery or introduction into evidence in any proceedings, and may only be disclosed as necessary to carry out the purposes of the state team or local teams.
- (2) In addition, all otherwise confidential information and records created by a local team in the exercise of its duties are confidential, are not subject to discovery or introduction in evidence in any proceedings, and may only be disclosed as necessary to carry out the purposes of the state or local teams. Release to the public or the news media of information discussed at official meetings is strictly prohibited. No member of the state team, a local team not any person who attends an official meeting of the state team or a local team, may testify in any proceeding about what transpired at the meeting, about information presented at the meeting, or about opinions formed by the person as a result of the meeting.
- (3) This subsection shall not, however, prohibit a person from testifying in a civil or criminal action about matters within that person's independent knowledge.
- (f) Each statutory member of a local child fatality review team and each non-statutory member of a local team and each person otherwise attending a meeting of a local child fatality review team shall sign a statement indicating an understanding of and adherence to confidentiality requirements, including the possible civil or criminal consequences of any breach of confidentiality.

[Acts 1995, ch. 511, § 5.]

68-142-109. Staff and consultants.

To the extent of funds available, the state team may hire staff or consultants to assist the state team and local teams in completing their duties.

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